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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155329 03/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1302 N LESLEY AVE ROSEWALK VILLAGE AT INDIANAPOLIS INDIANAPOLIS, IN46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE K0000 K0000 The creation and submission of this Plan A Life Safety Code Recertification and of Correction does not constitute an State Licensure Survey was conducted by admission by this provider of any the Indiana State Department of Health in conclusion set forth in the statement of deficiencies, or of any violation of accordance with 42 CFR 483.70(a). regulation. Survey Date: 03/15/11 This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Facility Number: 000222 Allegation of Compliance and requests a Provider Number: 155329 Facility Revisit on or after 3/30/2011 AIM Number: 100274950 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Rosewalk Village at Indianapolis was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas not separated from the corridor. Battery operated smoke

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

detection is provided in all the resident

TITLE (X6) DATE

04/12/2011

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9Z9L21 Facility ID: 000222 If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155329			(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION	li i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		1302 N	NDDRESS, CITY, STATE, ZIP COD LESLEY AVE APOLIS, IN46219	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
l	sleeping rooms. capacity of 182 a the time of this v  Quality Review by Safety Code Special 03/22/11.  The facility was	The facility has a and had a census of 168 at isit.  Robert Booher, REHS, Life list-Medical Surveyor on found not in compliance entioned regulatory		CROSS-REFERENCED TO THE APP	ROPRIATE	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155329	B. WING			03/15/2011	
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				LESLEY AVE		
	ALK VILLAGE AT IN	DIANAPOLIS			APOLIS, IN46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	7700	TAG			DATE
K0029		ervation and interview,	K00	29	K029 NFPA 101 Life Safety Code Standard		03/30/2011
SS=E	=	to ensure 1 of 5 doors			Sumum		
	serving hazardou				What corrective action(s) will be ta		
	mechanical room	ns with natural gas fired			for those residents found to have be	en	
	water heaters are	equipped with self			affected by the deficient practice?		
	closing devices of	on the doors. This			In-house maintenance installed a		
	deficient practice	e could affect any			self-closing device on Mechanical ro		
	resident, staff or	visitor in the vicinity of			#5. In-house maintenance removed to wooden access panels and sealed the	he	
	Mechanical Room	-			penetrations with two layers of 5/8"		
					fire-rated sheetrock.		
	Findings include:						
	1 mamgs merade	•			How will you identify other residen	to	
	Based on observa	ation with the			having the potential to be affected h		
					the same deficient practice and wha		
	-	pervisor during a tour of			corrective action will be taken?		
	-	11:00 a.m. to 1:45 p.m.			All residents have the potential to be		
	· ·	chanical Room # 5			affected by this alleged deficient prac	tice.	
		ural gas fired water					
	heaters and is no	t equipped with a self					
	closing device or	the entry door. Based			What measures will be put into place or what systemic changes will you	ce	
	on interview at th	ne time of observation,			make to ensure that the deficient		
	the Maintenance	Supervisor			practice does not recur?		
	acknowledged th	e entry door to			Maintananaa mada iti	,,	
	_	m # 5 is not equipped			Maintenance made an inspection of a hazardous areas to ensure that all doo		
	with a self closin				had self-closing devices and that there		
	With the State Closes	,			were no penetrations of the smoke ba		
	3.1-19(b)				walls.		
	J.1 17(0)				How the corrective action(s) will be	,	
					monitored to ensure the deficient		
	2. Based on obse	ervation and interview,			practice will not recur, i.e. what		
	the facility failed	to ensure 1 of 5			quality assurance program will be pinto place?	out	
	•	such as mechanical			mto piace:		
	rooms with natur	al gas fired water heaters			The maintenance director or their		
	are provided with	_			designee will make quarterly rounds		
	•	deficient practice could			as needed rounds to ensure that there door closers and no penetrations of w		
	Parations. 11118 (	actional practice could			door crosers and no penetrations of w	u113	

NAME OF PROVIDER OR SUPPLIER  B. WING	STREET ADDRESS, CITY, STATE, ZIP C	03/15/2011
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN46219	ODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF COLOREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE COMPLETION
affect any resident, staff or visitor in the vicinity of Mechanical Room # 1.  Findings include:	in each hazardous area room  The executive director will inspect hazardous rooms for on daily rounds.	periodically
Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:45 p.m. on 03/15/11, Mechanical Room # 1 contains two natural gas fired water heaters. The rear wall of Mechanical Room # 1 has two wooden hinged doors each measuring one foot square which are not smoke resistant and provide access to the adjoining Nurses Supply room. Based on interview at the time of observation, the Maintenance Supervisor stated he was unaware of the purpose of each hinged door and acknowledged the two square wooden hinged doors are not smoke resistant.  3.1-19(b)	The maintenance director versults of inspection quarte committee. The CQI Commercial review results quarterly to compliance.	rly to the CQI mittee will

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			COMPLI		
ANDILAN	or connection	155329	A. BUII			03/15/20	
		100020	B. WIN		ADDRESS STEEL STEE	00, 10,20	· · ·
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROSEWA	ALK VILLAGE AT IN	DIANAPOLIS		l	NAPOLIS, IN46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K0050		review and interview, the	K00		K050 NFPA 101 Life Safety		03/30/2011
		ensure 1 of 4 second shift	Koc	30	Code Standard		03/30/2011
SS=F	_	ed the transmission of a			What corrective action(s) will be ta	lzon	
		LSC 19.7.1.2 requires			for those residents found to have be		
	_	th care occupancies to			affected by the alleged deficient		
		mission of the fire alarm			practice?		
	signal. This defi	cient practice affects all			The Executive Director has rein-serv	iced	
	occupants in the	facility including			the maintenance director regarding transmission of the fire alarm signal		
	residents, staff ar	nd visitors.			quarterly on each shift except for dril		
					conducted between the hours of 9 pm and 6 am.		
	Findings include	:			and o am.		
					How will you identify other residen		
		of "Monthly Fire Drill			having the potential to be affected the same alleged deficient practice,		
	Report" document				what corrective action will be taken		
	•	pervisor from 9:25 a.m. to			All residents have the potential to be		
		/15/11, the second shift			affected by this alleged deficient pract		
		ed at 7:35 p.m. on					
		include transmission of					
	_	mal. The 12/03/10 fire			What measures will be put into pla	ce	
	drill report stated				or what systemic changes you will make to ensure that the deficient		
	at the time of rec	ted." Based on interview			practice does not recur?		
		pervisor stated the facility					
	•	alarm system each time a			The maintenance director has been		
		icted but acknowledged			rein-serviced regarding requirements	for	
		drill did not include the			transmission of the fire alarm signal.  The maintenance director will transm	nit	
		he fire alarm signal.			the alarm on each shift quarterly exce	ept	
		S			for drills conducted between the hour 9 pm and 6 am. The maintenance	rs of	
	3.1-19(b)				director or their designee will log the	,	
					transmission of the alarm signal on the	ne	
					monthly fire drill report. The maintenance director or their designed	ee	
					will review the fire drill report with t		
					executive director monthly.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9Z9L21

Facility ID:

000222

If continuation sheet

Page 5 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155329	A. BUILDING		COMPLETED 03/15/2011
		100020	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/10/2011
NAME OF F	PROVIDER OR SUPPLIER			LESLEY AVE	
	ALK VILLAGE AT IN		INDIAN	NAPOLIS, IN46219	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?  The maintenance director or their designee will review the fire drill rep with the executive director monthly the shown the documentation of transmiss of the audible alarm.  The maintenance director or their designee will report results to the CC committee.  CQI Committee will review testing results monthly for 3 months and quarterly thereafter.	DATE  DATE  DOTE
			Ī		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155329	B. WING			<del></del>	
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				LESLEY AVE		
ROSEWA	ALK VILLAGE AT IN	DIANAPOLIS	INDIANAPOLIS, IN46219				
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE	
K0104		review, observation and	K01	04	K104 NFPA 101 Life Safety Code Standard	03/30/2011	
SS=E	interview; the fac	cility failed to properly			Standard		
	test and maintain smoke dampers in			What corrective action(s) will be taken		ken	
	accordance with	LSC Section 8.3.5 and			for those residents found to have be	en	
	NFPA 90A, 1998	Edition. NFPA 90A			affected by the deficient practice?		
	Section 3-4.7. red	quires at least every 4			An outside contractor has made a		
		s be operated to verify			thorough inspection of the facility to		
	1	the latch, if provided,			identify all smoke dampers and has		
		and moving parts shall			performed the proper test and maintenance on all		
	·	necessary. This deficient			Smoke dampers; operating each to ve	rify	
		fect all residents, staff			that they fully close and that all movi	· ·	
	*				parts are lubricated.		
		e Therapy Gym if smoke			How will you identify other residen	ts	
	•	operate properly during a			having the potential to be affected by	l l	
	fire.				the same deficient practice and wha	- I	
					corrective will be taken?		
	Findings include:				All residents have the potential to be		
					affected by this alleged deficient prac	tice	
	Based on record	review and interview					
	with the Mainten	ance Supervisor from			What measures will be put into place	ce	
		0 a.m. on 03/15/11,			or what systemic changes will you make to ensure		
		ords for smoke dampers			deficient practice does not recur?		
		e for review. Based on			_		
	observation with				Maintenance director has placed on		
		g a tour of the facility			preventative maintenance calendar to schedule the testing of the smoke		
	•	•			dampers at least once every four year	S.	
		to 1:45 p.m. on 03/15/11,					
	_	pers were observed in			An and day of the state of	[	
		ork in the Therapy Gym.			An outside contractor has set up a schedule of maintenance and testing t	·	
		dampers were observed			be performed every four years on all	-	
	-	ased on interview at the			smoke dampers.		
	time of observati	on, the Maintenance			How the commenti		
	Supervisor ackno	wledged there is no			How the corrective action(s) will be		
	documentation of	f smoke damper testing			monitored to ensure the deficient practice will not recur,		
	within the last for	-					
		•			i.e. what quality		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9Z9L21

Facility ID:

000222

If continuation sheet

Page 7 of 12

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION	(X3) DATE COMPI 03/15/2	LETED
ROSEWA	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  1302 N LESLEY AVE INDIANAPOLIS, IN46219			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE
	3.1-19(b)			assurance progran be put into place?	ı will	
				The CQI Committee will review to f testing and maintenance of the dampers and will review the need testing on an annual basis to ensu testing and maintenance are perfoleast every four years.	smoke for re	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155329	B. WING			03/15/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LESLEY AVE		
	ALK VILLAGE AT IN	DIANAPOLIS			APOLIS, IN46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	77.04	TAG	·		DATE
K0130		ation and interview, the	K01	30	K130 NFPA 101 Miscellaneous		03/30/2011
SS=E	_	ensure the care and			What corrective action(s) will be ta	ken	
		of 1 rolling fire doors			for those residents found to have be	en	
	was in accordance	ee with NFPA 80. LSC			affected by the alleged deficient		
	4.5.7 requires any	y device, equipment or			<ul><li>practice?</li><li>An outside contractor has inspected a</li></ul>	nd	
	system which is	required for compliance			tested the rolling fire door to check for	or	
	with the provisio	ons of this Code, such			proper operation and full closure. The	ne	
	device, equipmen	nt or system shall			release mechanism was reset in accordance with the manufacturer's		
		ntained unless the Code			instructions.		
	exempts such ma	nintenance. NFPA 80,					
	•	e Standard for Fire Doors			How will you identify other residen		
		vs, Section 15-2.4.3			having the potential to be affected be the same alleged deficient practice a		
		contal or vertical sliding			what corrective action will be taken		
	_	oors to be inspected and					
	_	•	1	All residents have the potential to be affected by this alleged deficient practice.			
		check for proper			affected by this affeged deficient prac	tice.	
	•	ll closure. Resetting of			What measures will be put into place	ee	
		anism shall be done in			or what systemic changes you will		
		the manufacturer's			make to ensure that the deficient practice does not recur?		
		vritten record shall be			practice does not recur?		
	maintained and s	shall be made available to			The Maintenance director has placed	on	
	the authority hav	ing jurisdiction. This			preventative maintenance calendar to		
	deficient practice	e could affect residents,			schedule an annual test and inspection the rolling fire door.	1 01	
	staff and visitors	in the Main Dining			the forming the door.		
	Room.				How the corrective action(s) will be		
					monitored to ensure the deficient		
	Findings include	:			practice will not recur, i.e. what quality assurance program will be p	nut .	
	<u> </u>				into place?	•	
	Based on observa	ation with the				_	
		pervisor during a tour of			The CQI Committee will review resu of testing and maintenance of the roll		
	_	11:00 a.m. to 1:45 p.m.			fire door and will review the testing of	-	
	-	re is a rolling fire door			an annual basis to ensure testing and		
		_			maintenance is performed at least		
		ening from the kitchen to			annually.		
	tne Main Dining	Room without an					
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9Z9L21

Facility ID:

000222

If continuation sheet

Page 9 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155329			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  03/15/2011			ETED	
	PROVIDER OR SUPPLIER		1	1302 N	LESLEY AVE APOLIS, IN46219	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Room is open to interview at the t Maintenance Sup annual inspection	on tag. The Main Dining the corridor. Based on ime of observation, the pervisor stated there is no in or test of the vertical to check for proper all closure.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155329	B. WING			03/15/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1302 N	LESLEY AVE		
	ALK VILLAGE AT IN		INDIANAPOLIS, IN46219		APOLIS, IN46219		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	77.0.1	TAG	K143 NFPA 101 Life Safety Code		DATE
K0143		ation and interview, the	K01	43	Standard Standard		03/30/2011
SS=E	facility failed to ensure 2 of 2 areas used						
		ng of oxygen was					
	-	ny portion of a facility			What corrective action(s) will be tall for those found to have been affected		
	wherein residents	s are housed, examined,			by the alleged deficient practice?	ru	
	or treated by a fin	re barrier of 1 hour fire					
	resistive construc	ction. This deficient			The stationary liquid oxygen contained		
	practice could af	fect all residents, staff			have been removed from rooms 100 a	and	
	_	e vicinity of resident			****		
		esident Room 111.			Maintenance inspected all rooms to		
					ensure that there were no additional		
	Findings include:				liquid oxygen containers in non-rated rooms.		
	i manigs merade	•			Tooms.		
	Pagad on observe	ation with the			How will you identify other residen		
				having the potential to be affected by			
	_	pervisor during a tour of			the same deficient practice, and wh corrective action will be taken?	at	
	_	11:00 a.m. to 1:45 p.m.					
		om 100 and Room 111			All residents have the potential to be		
		tionary liquid oxygen	affected by this alleged defi		affected by this alleged deficient prac	tice.	
	_	n a resident room with a					
	nonrated door an	d with a nonrated ceiling					
	and walls. Based	d on interview with the			What measure will be put into place		
	RN Unit Manage	er at the time of			what systemic changes will you mal to ensure that the deficient practice		
	observation, the	RN Unit Manager stated			does not recur?		
	•	s under hospice care					
	administered by	-			Both the Hospice company and the		
	•	ionary liquid oxygen			Oxygen company were notified that r liquid oxygen containers could be sto		
	-	in each of these two			in non-rated rooms and that no	100	
		ills oxygen to portable			transfilling of oxygen canisters can be	e	
		e resident rooms. The			performed in non-rated rooms.		
					How the corrective action(s) will be	,	
	_	pervisor acknowledged			monitored to ensure the deficient		
		n canisters used for			practice will not recur, i.e. what		
		en in Room 100 and			quality assurance program will be p	out	
	Room 111 are in	nonrated resident			into place?		
			l				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
ANDILAN	or correction	155329	A. BUILDING   03/15/20:				
			B. WING	TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		1302 N LESLEY AVE				
	ALK VILLAGE AT IN		IN.	NDIAN	APOLIS, IN46219		
(X4) ID		TATEMENT OF DEFICIENCIES	II	- 1	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	sleeping rooms.	ESC ISENTI TINO IN ORGANITOTO	1		The maintenance director or their		5.112
steeping rooms.				designee will monitor for compliance			
	3.1-19(b)				during monthly and routine rounds.  The executive director will monitor for	or	
					compliance during daily rounds.	,,	
					Results of monthly maintenance roun	ds	
					will be reviewed by the CQI Committee	tee	
					monthly for 3 months and quarterly thereafter.		